The Depersonalization of Health Care

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Martin Buber (1), the philosopher, wrote, "The basic word I-You can only be spoken with one's whole being. The basic word I-It can never be spoken with one's whole being." In the managed care era of the 1990s, it is worth exploring how Buber's thoughts can be translated to the treatment of psychiatrically ill patients.

As an idealistic medical student in the 1980s, I, like others in training, was distressed by the suffering I witnessed. I was disturbed not only by patients' unenviable experience of illness, but also by the health care system's seeming indifference to their suffering. I know now that many people who witness suffering on a daily basis inure themselves to the pain it evokes in whatever ways they can. But I remember at that time being disturbed by certain attitudes toward patients, attitudes reflected in slang terms used to describe particular people.

I now understand that these terms were engendered less by attitudes of indifference and more by exhaustion and despair among those trying to treat human beings with difficult or recalcitrant health problems. "Gomer" (Get Out of My Emergency Room) was one term I found especially objectionable, but there were others I have happily forgotten. During those formative years I also found it difficult when attending physicians or residents referred to the "appendix" in room 305 or the "ulcer" in room 218. Where were the human beings, I wondered, who suffered from the sick appendix or from the painful, unremitting ulcer?

Now my colleagues in psychiatry find that depersonalization of health care has accelerated in a different direction—the basic relationship between a treating clinician and a patient has been transformed from the more personal, even sacred, "I-You" state to one that is less personal, less intimate, less empathic. In recent years, clinicians have been encouraged by business and insurance interests to revise clinical language from one that expresses empathy, intimacy, and compassion to one better suited to a business climate. Clinicians have been encouraged to dispense with the term "patient" and to substitute business-related terms such as "client," "consumer," or even "customer."

These latter terms are more in tune with the business interests of the current health care industry. But they can lead us away from Buber's "I-You" relationship, and toward an "I-It" relationship in which patients are seen as mere objects. Worse than the degeneration of language that is significant to the meaning of the patient-therapist relationship is clinicians' uncritical acceptance and even embrace of this new vocabulary.

When do meaning and value in the use of language become problematic, and why is this issue relevant to emergency psychiatry? The patient-therapist relationship has fiduciary qualities, but it is primarily a healing relationship. A patient who suffers is not healed by slogans or buzzwords; referring to a patient as a "customer" neither assists nor hastens the healing process. In fact, this vocabulary denies at a very basic level the intimate, almost sacred nature of the therapeutic relationship.

Likewise, "empowerment," which suggests that patients have increased authority in clinical decision making, offers little more than a quick fix and a feel-good remedy for therapists who are disturbed by the idea of acting as a long-term advocate for the patient. Healing of the brain and mind takes time. The myth of patient "empowerment" may allow a therapist to dispense with the patient before any healing has taken place—and possibly before the insurance money runs out.

There is no question that clinicians should be adamant in demanding cost-effective treatments for their patients. However, the choice of treatment modality can never be motivated simply by profit. Although reports that improved treatment outcomes go with lower costs may attempt to "prove" otherwise, Americans are quickly losing faith in the idea that managed care is truly cost-effective. Managed care interests have responded by spending up to $60 million in 1998 to lobby Congress against managed care reform (2).

Consumerism and power, the vocabulary of the business deal, is a vocabulary that diminishes the "I-You" relationship that is intrinsic to the healing process. Any physician will attest that even pharmacological agents are more effectively managed in the context of the "I-You" relationship, that is, in a relationship that involves compassion, empathy, attentive listening, and, of course, time.

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In free-market enterprise outside of the medical field, "clients" and "consumers" may have a wide array of choices about how to use their income, assuming that they have adequate purchasing power. Consumers are free to choose how they wish to spend their dollars. Simple issues of supply and demand determine underlying costs of such decisions.

However, consumers and patients are fundamentally different in their degree of choice and the nature of their relationship with those from whom they receive goods or services. For example, a patient may not fully realize the extent or nature of his or her mental illness and may have limited ability to make an independent decision to seek treatment and to select a particular type of treatment from a range of treatment options. Therefore, the simple view of seeing a patient as a "consumer," that is, one who acquires goods or services for direct use, is missing the point.

Moreover, patients with chronic psychotic syndromes have little opportunity to acquire or manage large sums of money as long as cognitive difficulties or hallucinations persist. Thus, unlike consumers who base their choices in purchasing on the financial resources they have, most patients with severe mental illnesses do not have the financial resources to gain access to the expensive and long-term care their illnesses require.

One hesitates to contemplate the implications for treatment of patients with mental illness in a world where the word "patient" is no longer part of a clinician's daily vocabulary. Changes in language sometimes constitute a subtle or covert method for changing perception. Restricting use of the term "patient" subtly moves control of the field of psychiatry away from the realm of clinicians and into the hands of business moguls. Such changes might be acceptable if a revision of language could catalyze a decline in overall spending for health care services or produce models of fiscal excellence. However, this is not always the case.

What happens when health care organizations are managed by pure business principles, with little emphasis on patient-clinician relationships, was demonstrated by last year's collapse of Pennsylvania's Allegheny Health System, where marketing and business principles were used to realign the entire health care network. In addition to the bankruptcy of seven hospitals, two medical school affiliates were in imminent danger of closing. Yet according to the *Philadelphia Inquirer,* the chief executive officer of the Allegheny system received total compensation of more than $1 million during that same period of time (3).

I strongly suggest we remove the terms "consumer," "client," and "customer" from the clinician's vocabulary. This change will free us from the "I-It" realm and return us to the proper "I-You" relationship that the terms "clinician" or "physician" and "patient" imply. Permutations in the abstract realm of language change perspective in very real yet subtle ways. Any high school student who has read George Orwell's *1984* understands this principle.

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The language of clinical treatment and therapy needs to return from its business-oriented present to its patient-oriented past. The language of treatment should emphasize the language of the heart, the mind, and the spirit, thus ensuring that our work and clinical strivings return to their proper sense of duty—to care for the suffering and illness of our fellow human beings.

Changes in language bring about changes in customs and ideals, which is why totalitarian regimes abolish the language and literature of those who have resisted those regimes. Where language is decimated, so are the people who communicate in that language. In mental health care, evidence of this process can be found in the difficulties patients have in gaining access to care now that clinicians are merely "providers" and persons with mental illnesses are merely "customers" to be "empowered" rather than people to be healed.

As an emergency psychiatrist, I enjoy working in a specialty that requires that I remain in many ways a generalist. On a typical day, I might be required to discuss treatment modalities ranging from transcranial magnetic stimulation to the future use of substance P antagonists to techniques of crisis intervention with suicidal adolescents. I am also an advocate of efficient, cost-effective clinical care. But by observing and treating those who experience psychiatric emergencies, I have come to realize that a sense of the "sacred" is often essential in inducing a permanent sense of healing. Critical to successful outcomes are biological intervention; social, economic, and cultural factors; and comprehension of psychodynamics. However, in psychiatry in particular, it is the sense of the sacred embodied in the "I-You" relationship between the patient and therapist that ultimately allows healing. ♦

References

1. Buber M: I and Thou. New York, Scribner's, 1970
2. $60 million spent to fight reform. Post and Courier, Charleston, SC, Nov 28, 1998, p 5B
3. The region's highest-paid hospital chief earned $4.3 million. Philadelphia Inquirer, Nov 15, 1998, p D12